

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/11/2015
NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00186760.</p> <p>Complaint IN00186760 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: December 11, 2015</p> <p>Facility number: 005722 Provider number: 005722 AIM number: N/A</p> <p>Residential census: 105</p> <p>Sample: 04</p> <p>The Hearth at Stones Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00186760.</p> <p>QR completed by 34849 on December 14, 2015.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE